

Canadian Cardiovascular Congress



Co-hosted by the Canadian Cardiovascular Society and the Heart and Stroke Foundation of Canada



PLEASE PLAN TO ATTEND

TUESDAY, October 27

“Optimizing Outcomes in ACS”

7:00-9:00, Delta Hotel Conference Centre, 3rd Floor

“5th Annual Medical Debate in Lipid Management – Meeting the Challenge of Evolving Evidence”

7:00-9:00, Crowne Plaza Hotel, Alberta AB, Lobby Level

9:00-9:45 John Keith Lecture: “Convergence of Human Genetics and Stem Cell Biology: The Future of Medicine” (Hall D, Sec. 1, Pedway Level)

9:45-10:30 Wilfred G. Bigelow Lecture: “Aortic Valve Repair – State-of-the-Art” (Hall D, Sec. 1, Pedway Level)

11:00-12:30 CIHR/ICRH Distinguished Lecture in Cardiovascular Sciences: “Stem Cells for Cardiac Regeneration” (Hall D, Sec. 1, Pedway Level)

14:00-15:30 Debates—Current Controversies in Cardiovascular Sciences (Hall D, Sec. 2, Pedway Level)

“A Global Perspective of Cardiovascular Disease Burden and Treatment”
18:30-21:30, Hall D, Pedway Level

WEDNESDAY, October 28

“Expert Opinions: Current Issues in Cardiology”

7:00-9:00, Westin Hotel, MB/SK, Banquet Level

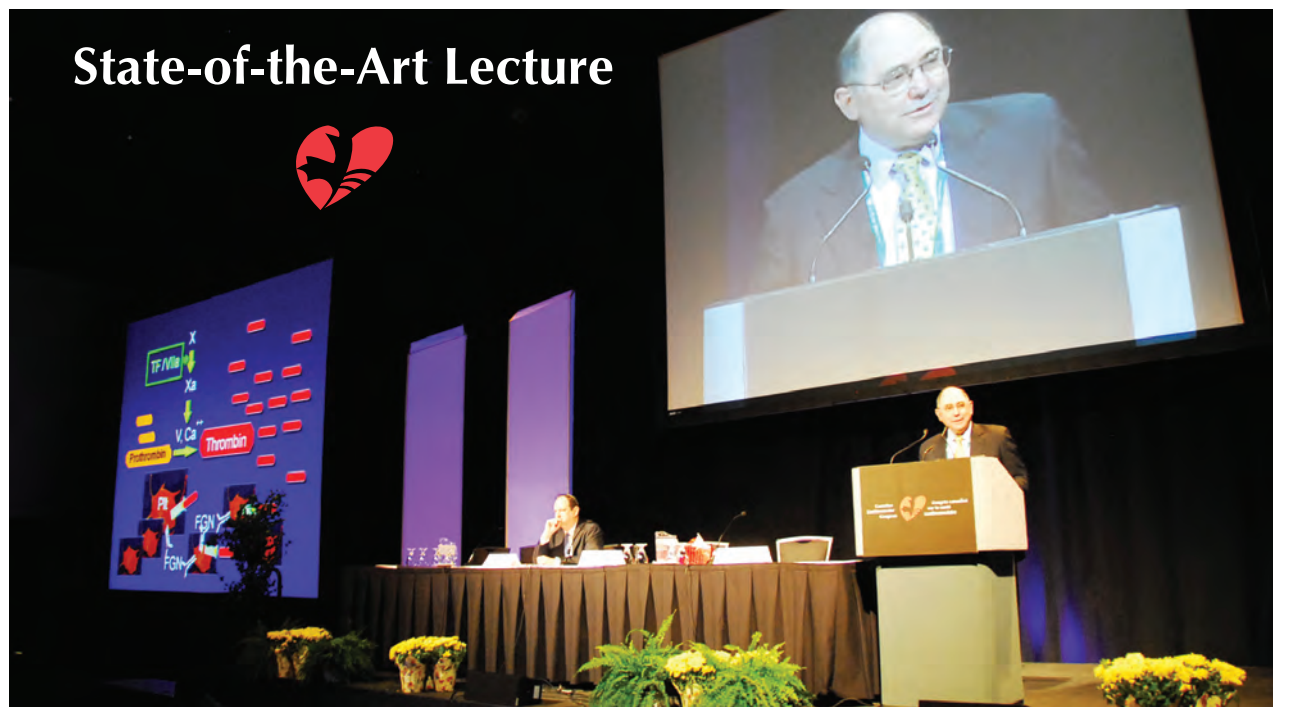
9:00-10:30 Late Breaking and Featured Clinical Trials (Salon 08, Meeting Level)

INFO CARDIO

TUESDAY/WEDNESDAY EDITION

14th Anniversary of the Official Newspaper of the Annual Canadian Cardiovascular Congress
October 24-28, 2009 / Edmonton, Alberta

State-of-the-Art Lecture



INFO CARDIO

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State of the Art Lecture:

“Antiplatelet Therapy in the Management of Ischemic Heart Disease”

The advent of new antiplatelet strategies are good news for patients with ischemic heart disease provided they are used in appropriately selected candidates and are taken as prescribed.

State-of-the-Art lecturer Dr. Elliott Antman, Director, Samuel A. Levine Cardiac Unit, Brigham and Women's Hospital and Professor of Medicine, Harvard University, Boston, Massachusetts, described how platelets become activated by a series of processes that culminate in platelet aggregation. “Aggregated platelets form an enormous surface area on which the prothrombinase complex sits,” Dr. Antman explained, “and this complex is critical for converting prothrombin into thrombin so there is a networking between the coagulation cascade and the activated and aggregated platelets.” This system can be quieted down by using agents that intercept the coagulation cascade and inhibit platelet function.

Regarding agents that inhibit platelets themselves and not those which inhibit the coagulation cascade elsewhere, Dr. Antman noted that ASA reduces thromboxane A₂ formation, thereby inhibiting platelet activation and aggregation. The glycoprotein IIb/IIIa inhibitors block each of these receptors, in turn controlling platelet aggregation and thrombus formation, he added. As the most widely used thienopyridine to date, clopidogrel inhibits the P2Y₁₂ receptor on platelets; as an inactive parent compound, it must be converted to its active metabolite before it can bind to the receptor and unleash its antiplatelet activity.

Earlier studies using ticlopidine plus ASA clearly demonstrated that dual antiplatelet therapy was consistently more effective in the prevention of major acute coronary events (MACE) than ASA alone, as Dr. Antman noted. However, ticlopidine was not well tolerated in the setting of stents, so once clopidogrel was developed, it was widely adopted. Nevertheless, as Dr. Antman discussed, there is considerable variability in response to clopidogrel, with some

patients achieving minimal amounts of platelet inhibition following a 300-mg loading dose of the agent. Yet even at a 600-mg loading dose, “there is still a significant proportion of patients who do not achieve an adequate response,” Dr. Antman confirmed.

There is also a significant interaction between the dose of clopidogrel administered and the dose of ASA used, he added, which demands cautious interpretation of double-dose clopidogrel trials. As of this year, prasugrel, another reversible inhibitor of the P2Y₁₂ receptor, is now approved in the US for a variety of indications. As with clopidogrel, prasugrel must be converted from the parent compound into its active metabolite before it becomes active. The main difference between the two thienopyridines is in their ability to generate the active metabolite; concentrations with clopidogrel are much lower than those achieved with prasugrel. Clopidogrel is relatively more dependent on the CYP2C19 pathway to generate its active metabolite than is prasugrel and patients who have a reduced CYP2C19 function allele have a marked inability to generate the active metabolite. This is not observed with prasugrel, as Dr. Antman noted. Clinical trials such as TRITON-TIMI 38 have shown that prasugrel results in significantly fewer MACE compared with clopidogrel although the greater levels of platelet inhibition achieved with prasugrel came at a slight cost of increased bleeding.

In contrast, ticagrelor does not undergo active transformation because the parent compound is already active. In the recently published PLATO trial, the investigational agent was associated with significant reductions in MACE as well as total mortality compared with clopidogrel and bleeding risks were acceptable. Cangrelor, another novel antiplatelet agent, has also been studied in several trials but the studies were stopped because there was no evidence this particular antiplatelet was more effective than clopidogrel. □



INFO-Cardio, the official newspaper of the CCC, is made possible through collaboration of industry partners.

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Wilfred G. Bigelow Lecture: “Aortic Valve Repair – State of the Art”

A systematic, repair-oriented functional classification system co-developed by this year’s Wilfred G. Bigelow lecturer, Dr. Gebrine El Khoury, Professor and Chief, Cardiovascular and Thoracic Surgery, Cliniques Universitaires Saint-Luc, Université catholique de Louvain, Brussels, Belgium, helps predict both the surgical techniques required to repair aortic insufficiency and the durability of the repair technique.

As Dr. Munir Boodhwanti and colleagues, including Dr. El Khoury, write (*J Thorac Cardiovasc Surg* 2009;137:286-94), valve repair for aortic insufficiency requires a tailored surgical approach determined by leaflet and aortic disease. Unlike mitral valve insufficiency, until Dr. El Khoury developed one, aortic valve insufficiency did not have a classification system, thereby hindering communication between cardiologists, anesthesiologists and surgeons. Borrowing from the Carpentier classification of mitral valve insufficiency, Dr. El Khoury and colleagues have gone on to develop a similar classification of aortic valve insufficiency and in their recent paper, describe their experience with aortic valve repair according to their systematic approach.

From December 1995 to March 2007, a total of 264 consecutive patients with at least a 2+ aortic valve insufficiency underwent surgical procedures on the aortic valve, aortic root and ascending aorta. Over the same interval, the Brussels-based team developed a classification system for aortic insufficiency according to mechanisms of disease and the repair techniques used. “As in the Carpentier classification of mitral valve disease, regurgitation associated with normal leaflet motion is designated as type I,” the authors write. There are several different subtypes to type I based on mechanisms and repair techniques. Type II is due to cusp prolapse, while type III is due to leaflet restriction.

In reviewing their experience, the authors note that 376 lesions were diagnosed in their cohort of 264 patients, approximately two-thirds of whom had solitary lesions,



Dr. Gebrine El Khoury

and most of the remaining patients had two lesions. “Fifty per cent of lesions were type I... 35% were type II... and 15% were type III,” the authors add. By retrospectively comparing the predicted surgical technique with the actual technique used, Dr. El Khoury and colleagues determined that “the vast majority” of patients with either single or multiple lesions underwent repair with the techniques predicted by their disease classification. For example, for isolated type Ia disease caused by sinotubular junction (STJ) dilatation and ascending aortic aneurysm, the classification predicts STJ annuloplasty with subcommissural annuloplasty to stabilize the ventriculoaortic junction (VAJ): 100% of patients with isolated type Ia disease underwent STJ remodelling and 82% underwent subcommissural annuloplasty. “Overall, patients underwent surgical repair as predicted by the aortic insufficiency classification in 82% to 100% of cases,” the authors report, although their system did not predict adjunctive repair techniques, which were used in 4% to 35% of patients.

At a median follow-up of 47 months, 95% of the cohort were still alive and 87% were still alive at eight years. Freedom from aortic valve reoperation at five and eight years was 92% and 91%, respectively, while freedom from aortic valve replacement at five and eight years was 94% and 93%, respectively. Of all the types of aortic insufficiency classified, type III caused by cusp restriction was a risk factor for recurrent aortic insufficiency at follow-up.

As the authors observe, aortic valve repair has numerous advantages over prosthetic valve replacement, including hemodynamic benefits relative to a rigid prosthetic valve stent; avoidance of a mechanical prosthesis, which often would be required in a young population such as this one; and reduction in the risk of thromboembolic and anticoagulation-related complications. □

The Wilfred G. Bigelow lecture will take place Tuesday, October 27, 9:45-10:30, Hall D, Sec. 1, Pedway Hall.

CIHR/ICRH Distinguished Lecture in Cardiovascular Sciences: Focus on cell-based strategies

Cardiology is poised for a revolution in which cell-based strategies will be used to regrow healthy heart muscle after myocardial infarction (MI) or in chronic heart failure. This is the theme to be developed by this year’s distinguished CIHR/ICRH lecturer in cardiovascular sciences, Dr. Eduardo Marbán, Director, Cedars-Sinai Heart Institute and holder of the Mark Siegel Family Foundation Endowed Chair, Cedars-Sinai Medical Center, Los Angeles.

A phase I study under Dr. Marbán’s direction is already underway in which autologous cardiac stem cells are being reinfused back into the coronary arteries following an acute MI. A total of 24 patients are scheduled to undergo the autologous stem cell procedure; to date, 10 have been enrolled.

So far, evidence from both non-randomized and randomized trials indicates that intracoronary autologous bone marrow cell (BMC) infusion is safe and leads to small, long-term improvements in cardiac function following acute MI. However, as Dr. Marbán and colleague/lead author Dr. James Forrester explain in an editorial on intracoronary autologous BMC infusion (*J Am Coll Card* 2009;53:2270-2), BMCs do not reproducibly generate new myocardium and the observed benefit seen in clinical trials evaluating this approach is most reasonably attributed to paracrine effects. Although convenient, “BMC might not be the ideal cell for cardiac regeneration,” the authors observe.

The use of the patient’s own stem cells cultured from a cardiac biopsy has already reached clinical testing. The culturing of cardiac stem cells can be done several ways, but the process being used in the current phase I trial was developed by Dr. Marbán when he was affiliated with Johns Hopkins University. The University has subsequently filed for a patent on the process.



Dr. Eduardo Marbán

But in essence, cardiac stem cells are harvested during routine biopsy and maintained in primary culture for up to one week, upon which round cells budding off from the explants grow. These cells in turn are expanded to form multicellular clusters dubbed cardiospheres (CSPs), from which the cell product (CSp-derived cells or CDCs) can be rapidly elaborated. CDCs contain both cardiac stem cells and supporting cells from the heart. Dr. Marbán explains that CSPs and CDCs become excitable and contractile in synchrony with cardiomyocytes *in vitro*.

Other challenges to the success of autologous stem cell regeneration include the creation of a receptive cell environment to ensure cells survive and proliferate following infusion. “Timing of stem cell therapy remains a conundrum,” Dr. Forrester and colleagues acknowledge, “because the early inflammatory response creates an environment hostile to cell engraftment, whereas evolving fibrosis could inhibit later therapy in the subacute and chronic phase of healing.” In the ongoing phase I trial exploring this procedure, patients were required to have had their MI within one month of enrolling in the project.

“We must focus on the barriers to stem cell therapy at the level of the cell, its environment and the recipient tissue,” Dr. Forrester and colleagues conclude, “and identification of these barriers provides both a stimulus to ongoing research and a justification for the hope that stem cell therapy will ultimately achieve its much-anticipated potential.” □

The CIHR/ICRH Distinguished Lecture in Cardiovascular Sciences takes place on Tuesday, October 27, 11:00-12:30, Hall D, Sec. 1, Pedway Level.



Scott Lear, PhD

New HSFC chair in CV research prevention named in Vancouver

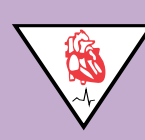
Scott Lear, PhD, Associate Professor of Health Sciences, Simon Fraser University, Vancouver, British Columbia, has just been named the Pfizer Heart and Stroke Foundation Chair in Cardiovascular Research Prevention, to be located at St. Paul’s Hospital in Vancouver.

“The chair position is quite unique in that it is really focused on prevention, which I believe is unique in Canada,” Dr. Lear told *INFO-Cardio*, “and while the overview is CVD prevention, we’ll be taking it from a population-wide level, looking at

how the communities where we live can foster behaviours that are either protective against CVD, or how communities where there are barriers to those behaviours could lead to obesity and CVD down the road.” Researchers will also be studying body fat in different ethnic groups and how it affects risk for diabetes and heart disease.

At the other end of the spectrum, Dr. Lear explained that the position will allow researchers to explore novel treatment strategies for patients with CVD, especially strategies that help deliver care into the homes of those who live outside of urban areas.

“The chair gives me the opportunity to take what I have been working on to another level and to build a stronger, more robust program, to form opportunities for collaboration both inside and outside of Canada, so it’s going to be very exciting,” stated Dr. Lear. □



Experts share insights as late-breaking trials bring the CCC to a close

As with every CCC, late-breaking featured trials will once more bring the CCC meeting to a close as experts share their insight into current and ongoing international trials of interest to cardiologists.

Effects of high vs standard dose clopidogrel and high vs low dose aspirin on major CV events and bleeding in 25,000 patients with ACS: The CURRENT OASIS 7 randomized trial. The study was designed to determine the efficacy and safety of high- vs. low-dose clopidogrel and high- vs. low-dose ASA in patients presenting with ACS and STEMI. Patients were scheduled for early PCI no later than 72 hours after randomization. Those in the high-dose arm received clopidogrel 600 mg on day 1, then 150 mg for seven days, followed by 75 mg until 30 days, while those in the standard-dose arm received 300 mg on day 1, followed by 75 mg until 30 days. Patients were also assigned to either 300 to 325 mg ASA or to 75 to 100 mg ASA a day. As reported by theheart.org, 7855 patients did not undergo PCI because either no significant CAD was seen on angiography or therapy was discontinued because patients required CABG. Among those who did undergo PCI, doubling the loading and maintenance doses of clopidogrel reduced CV death, MI and stroke by 15% compared with standard loading and maintenance doses, mostly driven by a 22% reduction in MI risk. There was also a 42% reduction in the risk of definite stent thrombosis. There was no difference in fatal bleeding, intracranial hemorrhage or CABG-related major bleeds between the two clopidogrel arms. Further findings will be presented by Dr. Shamir Mehta, McMaster University.

Viral anti-inflammatory treatment of unstable coronary syndromes: The VT-111 acute coronary syndrome trial. Given that inflammation underlies CVD, this trial sought to explore the safety of VT-111—a first-in-class, viral-derived anti-inflammatory therapeutic agent—along with standard care in patients with ACS treated with stents. Patients were randomized to intravenous VT-111 or placebo once daily for three days, starting immediately prior to intervention. At six months, no differences on key safety end points were seen between the active and control treatment groups, including coagulation parameters or adverse events, but there was a significant reduction in biomarkers of cardiac damage in the active treatment arm. VT-111 is a viral serine proteinase inhibitor that reduces monocyte migration to sites of vascular damage in animal models. Details of the trial will be presented by Dr. Jean-Claude Tardif, Montreal Heart Institute.

Effects of fondaparinux on echocardiographic measurements of LV function and prognostic implications of restrictive diastolic function post-ST-segment elevation MI. This was an echocardiographic substudy of the OASIS-6 trial in which LV systolic and diastolic function was compared between patients with acute STEMI treated with either fondaparinux or usual care. The prognostic implications of echocardiographic measures of LV systolic and diastolic function soon after STEMI were also determined. Results revealed no differences in LV systolic or diastolic function between the fondaparinux and usual-care arms. However, patients with an LV ejection fraction of 45% or lower and restrictive diastolic function had a major increase in the risk of major adverse cardiac events (MACE) at a hazard ratio of 8.85 compared to those with an LV ejection fraction of 45% or more and non-restrictive diastolic function. Restrictive diastolic function on its own was also associated with an increased risk of MACE, death and heart failure or cardiogenic shock in patients with an LV ejection fraction of 45% or more. Further details will be presented by Dr. Mahadevan Rajaram, McMaster University.

Substrate vs. trigger ablation for reduction of atrial fibrillation (STAR-AF): an international multicenter randomized trial. The STAR-AF trial compared three different strategies targeting AF ablation—“standard” pulmonary vein isolation; ablation of complex fractionated electrograms (substrate-based ablation); and a combined approach of pulmonary vein isolation plus substrate ablation. All procedures were carried out using percutaneous catheter ablation techniques. Only patients with drug-refractory, high-burden paroxysmal or persistent AF were included in the study, and the primary end point was freedom from any AF>30 seconds at one year. In this setting, 74% of patients undergoing the combined approach were free from AF at study end compared to 47% of patients who were treated with pulmonary vein isolation and 29% who underwent substrate-based ablation. Up to two procedures were allowed within the first six months, and even after two procedures, the combined approach was still better than either of the other two approaches and it also required fewer repeat procedures. Further details will be presented by Dr. Atul Verma, Southlake Regional Health Centre, Newmarket, Ontario.

Randomized comparison of targeted vs. usual LV lead placement in patients undergoing cardiac resynchronization therapy. Cardiac resynchronization therapy (CRT) synchronizes ventricular mechanical activity, improves cardiac output and reduces symptoms of heart failure. However, approximately 50% of patients do not respond to CRT, possibly because of sub-optimal placement of the LV pacing lead. In this study, patients receiving CRT were assigned to targeted or usual LV lead placement; the target site was defined as the latest LV segment on echocardiography. At a median follow-up of 30 months, investigators reported that LV lead placement at or near the target site was achieved in 80% of the targeted group vs. 44% of the usual group, even though targeted placement added an average of 17 minutes to the implant time. Overall, no significant differences were observed in the rate of response to CRT or survival between the two groups, although patients with ischemic cardiomyopathy had both a higher rate of response and improvement in survival with targeted vs. usual lead placement. Dr. Derek Exner, University of Calgary, will present further details.

Effect of ivabradine on CV outcomes in patients with stable CAD with LV dysfunction with limiting angina. A subgroup analysis of the BEAUTIFUL trial. This study was designed to assess whether the addition of ivabradine to standard therapy to lower heart rate might reduce CV death and morbidity in CAD patients with LV systolic dysfunction. In the overall population, ivabradine had no impact on the primary end point. However, it did reduce the risk of coronary events in patients with a heart rate of 70 bpm or greater at baseline. This subgroup analysis included patients whose limiting symptom at baseline was angina, approximately half of whom had a heart rate of 70 bpm or greater. At a median follow-up of 18 months, ivabradine reduced the primary end point by 24% compared with placebo and hospitalization for MI by 42%. Results were more striking in patients with a heart rate of at least 70 bpm, among whom ivabradine reduced hospitalization for MI by 73% and the need for coronary revascularization by 59%. Dr. Jean-Claude Tardif, Montreal Heart Institute, will present further details. □

The late breaking and featured clinical trials session will take place Wednesday, October 28, 9:00-10:30, Salon 08, Meeting Level.



Sally Brown

Heart and Stroke Foundation of Canada—The Mission Continues

The Heart and Stroke Foundation of Canada (HSFC) is working closely with municipalities and town planners in an effort to help ensure environments are more heart-healthy for Canadians. If that sounds out of the ordinary, it is anything but unusual for Canada's number-one health charity.

In their annual Heart Month Report Card issued a few years ago, the HSFC asked the public: “Has the suburban dream gone sour?” The answer, says the HSFC's CEO Sally Brown, appears to be yes.

“Many suburbs are notoriously wanting in sidewalks and other recreational amenities that make exercise not just pleasant but safe,” Brown told INFO-Cardio in an interview carried out in the midst of the CCC meeting. The HSFC is now working with city planners to ensure suburbs offer more recreational opportunities to improve overall CV health.

Healthy eating is another priority for the HSFC. “Last year's Report Card was on healthy foods,” Brown adds. Researchers priced healthy food items from the same chains across the country. Having identified “huge variations” in the prices—and availability—of healthy foods, the HSFC honed in on the policy implications

of their findings and will then advocate for initiatives to make healthy food more affordable and available. The HSFC has been instrumental in pushing government to eliminate trans-fats in processed foods, reduce dietary sodium intake and of course to eliminate exposure to first- and second-hand tobacco.

Efforts to improve the prevention, care and rehabilitation for stroke patients is also a significant part of the HSFC's mandate. As Brown notes, just a few years ago, very few interventions were available for stroke patients. Now, with evidence consistently showing that tissue plasminogen activator (tPA) can effectively lyse clots causing ischemic stroke, the HSFC is working to ensure that enough hospitals have CAT scanners differentiate ischemic from hemorrhagic stroke, and that the healthcare system is reorganized to improve outcomes for stroke patients.

HSFC remains active in supporting CVD researchers, apportioning up to \$60 million a year to support researchers in carrying out their areas of interest—obesity is one such key area. “Public health awareness, promotion, research, advocacy and policy remain the core activities of the HSFC,” confirms Brown, “and because we have a broad reach, donors who know us, and an active Web site, we can get information out to the media, raise these questions and try to find solutions.”

It is highly significant that this year's HSFC lecture by Dr. Robert Hegele told delegates that for all the fuss about genetic medicine, lifestyle remains the single most effective key to keeping heart disease and stroke at bay. “We have a full agenda,” states Brown, “but that is the way we like it because that is how the HSFC will make a real difference.” □



Q: Why do you come to the CCC meeting every year?



Dr. Charles Kerr, CCS President: I think it's just wonderful to see all my friends, to hear some excellent talks and science and to honour some of our members. Our awards night last night was absolutely sensational—both to award our young distinguished investigators as well as senior people who have served the Society for decades. And it's a terrific atmosphere; the camaraderie and friendships are probably what I value most. It's a place where you can access topnotch science and social events but it's really that feeling of closeness and family that makes it most special for me.

Nancy Cooper, Sunnybrook Health Sciences Centre, Toronto: I'm one of the cardiac care co-ordinators at Sunnybrook so there is always a lot of relevant information here about ACS and STEMIs; there's a good stent symposium I've been to, all good for what I do. It's also a wonderful way to reconnect with people I've met over the years at various conferences or with people who used to work in Toronto and who don't anymore, so it's networking as well as education. And it just happens that my son and daughter-in-law live in Edmonton and had twin baby boys in July so that might be part of it, too!



Robert Bayrak, Canadian Society of Clinical Perfusion, Edmonton: I come to see people I've known for years but coupled with that, it's a good educational experience as well. I learn a lot of new things and get some good reviews on things I once knew and have subsequently forgotten. There are some social events as well that are also interesting to go to, but again, it's catching up with friends and all that.

Dr. Robert Howard, St. Michael's Hospital, Toronto: I come because it's a place for great science, great educational events and I get to see all my friends. It's always a wonderful meeting, and I'm a big supporter of cardiovascular medicine in Canada and the best way to do that is to come to the meeting every year.



Cindy McMaster, Canadian Society of Cardiology Technologists, Calgary: I come to meet with colleagues we don't always get to meet with face to face and learn new skills and just interact with people professionally and socially. It's also a nice break from the routine but you always learn new skills that you can take back with you for yourself and your colleagues. I'm a visual learner, too, so I need to see and touch things to learn, not just read about them.

Dr. Marco Di Buono, Director of Research, Heart and Stroke Foundation of Ontario: There are really two main reasons. One, the calibre of the science at the CCC is first and foremost, so it's an excellent opportunity to learn about all the innovation that is going on across the nation and to some extent even internationally, and then being able to come back home to the Foundation and apply that in some kind of knowledge translation capacity so that we can meet our mission. But secondly and equally importantly, it is a very good opportunity for us to network with all the most important players in the healthcare sector who are at the forefront on CVD and that brings me back every year.



CCC 2009 Clinical Pearls

Suspension of detection in an implantable cardioverter defibrillator by eyeglasses. Watkins et al. felt that physicians should know that wearable items such as glasses which contain a neodymium magnet and which could come into close contact with either a pacemaker or a defibrillator have the potential to permanently alter the device's programming. They reported this following an incident in which they found that tachycardia detection was disabled when a patient who had received a single chamber defibrillator left his eyeglasses close to the defibrillator site. When the glasses were removed from their proximity to the device, tachycardia detection was re-enabled. The glasses had a neodymium magnet connecting the glasses at the bridge of the nose. It had previously been reported that such magnets interfered with pacemakers and ICDs up to a distance of 3 cm but not from magnetic interference by reading glasses. The authors felt that patients with pacemakers and defibrillators should be cautioned against wearing items such as eyeglasses that contain neodymium magnets. (Poster 107)

Prevalence and treatment patterns of lower extremity peripheral arterial disease in the community. Improved screening of adults for peripheral arterial disease (PAD) is feasible with the help of pharmacy students and would improve application of evidence-based therapies for PAD, according to Makowsky et al. As the authors reported, undergraduate pharmacy students screened a total of 362 adults over the age of 50 in urban and rural pharmacies as well as in physician offices located in northern and central Alberta. Students assessed CV risk factors, the use of evidence-based therapies (antiplatelets, ACE inhibitors, ARBs and statins) and applied the Edinburgh Claudication Questionnaire. They also measured ankle brachial index using Doppler ultrasound. Based on their findings, PAD was identified in 17 subjects, 14 (82%) of whom were unaware that they had PAD. Slightly over half had PAD alone, while about one-quarter had CVD alone and almost half had both PAD and CVD. Approximately half of those with PAD had typical symptoms of claudication. Using a similar approach, the authors estimated that the expected yield from screening ambulatory subjects over the age of 50 would be 10 PAD patients per 200 screened, some 80% of whom would be unaware of the diagnosis. (Oral 567)

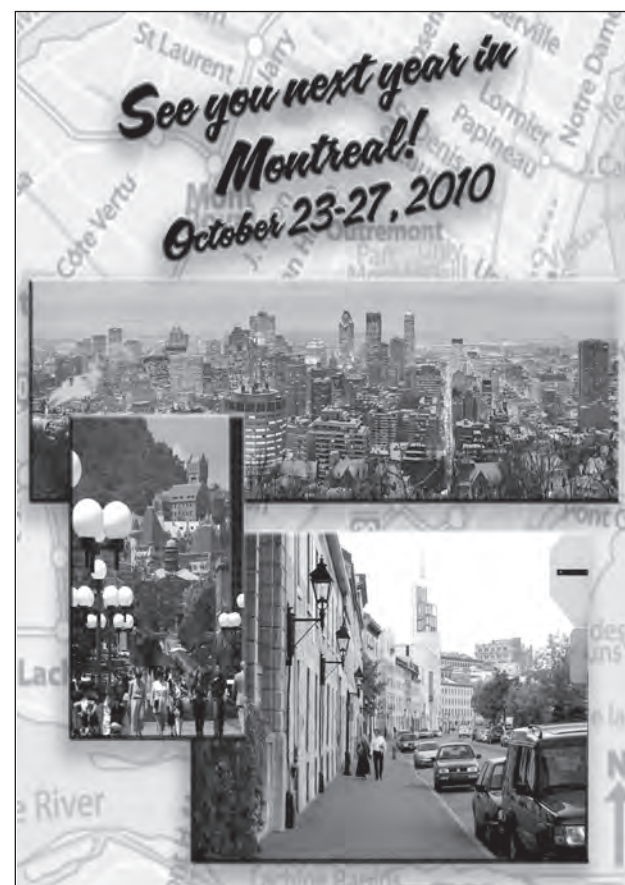
C-CHANGE workshop on harmonized guidelines: New initiative to optimize risk factor management

The Canadian Institutes of Health Research's Institute of Circulatory and Respiratory Health and the Public Health Agency of Canada (PHAC), in collaboration with other partners, are leading an exciting new initiative which aims to harmonize and integrate existing guidelines for optimal risk factors management for the prevention of cardiovascular disease (CVD).

The initiative, entitled C-CHANGE (Canadian Cardiovascular Harmonized National Guidelines Endeavour), is part of a national CVD prevention and chronic disease management strategy. The C-CHANGE workshop will provide an opportunity to learn about a systematic, evidence-based approach to harmonization and integration of guidelines on the treatment of CVD risk factors including hypertension, diabetes, smoking and lipids.

Key workshop presenters will include Dr. Peter Liu, Institute of Circulatory and Respiratory Health (Chair), University of Toronto, Ontario; Dr. Andrew Wielgosz, PHAC, University of Ottawa, Ontario; Dr. Andrew Pipe, University of Ottawa Heart Institute; Dr. James Stone, University of Calgary, Alberta; Dr. Denis Drouin, Canadian Hypertension Education Program (CHEP), Université Laval, Quebec City; Dr. Jacques Genest, McGill University, Montreal, Quebec; and Dr. Norm Campbell, CHEP, University of Calgary.

The C-CHANGE workshop will take place on Tuesday, October 27, 9:00-10:30, Salon 08, Meeting Level.



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